		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005926

Facility Name: Misericordia Home South

Address: 2916 W. 47th Street (Number) Chicago (City) 60632 (Zip Code)

County: Cook

Telephone Number: 773 973-6300 **Fax #** 773 973-4292

IDPA ID Number: 362170153-001

Date of Initial License for Current Owners: various

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	X Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amy Pow **Telephone Number:** 773 273-3032

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/1999 to 06/30/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Kevin Connelly
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 6/30/99

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	99	Skilled Pediatric (SNF/PED)	99	36,135	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	29,644	1,464	411	31,519	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,644	1,464	411	31,519	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.23%

D. How many bed-hold days during this year were paid by Public Aid? 756 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Respite

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	196,135	17,080	11,681	224,896		224,896	(12,709)	212,187			1
2	Food Purchase		218,057		218,057		218,057	(91,795)	126,262			2
3	Housekeeping	136,810	38,596	1,947	177,353		177,353	(52,897)	124,456			3
4	Laundry	113,880	8,565		122,445		122,445	(21,381)	101,064			4
5	Heat and Other Utilities			79,107	79,107		79,107	(23,594)	55,513			5
6	Maintenance	191,231	16,210	72,024	279,465		279,465	(73,678)	205,787			6
7	Other (specify):*											7
8	**TOTAL General Services**	638,056	298,508	164,759	1,101,323		1,101,323	(276,053)	825,270			8
	B. Health Care and Programs											
9	Medical Director			23,612	23,612		23,612	(788)	22,825			9
10	Nursing and Medical Records	3,479,821	520,352	4,994	4,005,167		4,005,167	(485,648)	3,519,519			10
10a	Therapy	488,535	7,282	158,900	654,717		654,717	(11,443)	643,274			10a
11	Activities			4,244	4,244		4,244	(9)	4,235			11
12	Social Services	69,372		6,770	76,142		76,142	(7,449)	68,693			12
13	Nurse Aide Training											13
14	Program Transportation		1,623		1,623		1,623	(6,181)	(4,558)			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,037,728	529,257	198,520	4,765,505		4,765,505	(511,518)	4,253,987			16
	C. General Administration											
17	Administrative	115,187			115,187		115,187	(20,012)	95,175			17
18	Directors Fees											18
19	Professional Services			12,742	12,742		12,742	(2,214)	10,528			19
20	Dues, Fees, Subscriptions & Promotions			13,594	13,594		13,594	(1,812)	11,782			20
21	Clerical & General Office Expenses	246,975	32,737	25,749	305,461		305,461	(52,680)	252,781			21
22	Employee Benefits & Payroll Taxes			1,046,129	1,046,129		1,046,129	(161,401)	884,728			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,384	17,384		17,384	(1,767)	15,617			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,662	41,662		41,662	(12,426)	29,236			26
27	Other (specify):*											27
28	**TOTAL General Administration**	362,162	32,737	1,157,260	1,552,159		1,552,159	(252,311)	1,299,848			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,037,946	860,502	1,520,539	7,418,987		7,418,987	(1,039,882)	6,379,105			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Misericordia Home South #0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			229,088	229,088		229,088	(81,413)	147,675			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			229,088	229,088		229,088	(81,413)	147,675			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	355,903	3,565		359,468		359,468	(359,469)	(1)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			321,388	321,388		321,388		321,388			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	355,903	3,565	321,388	680,856		680,856	(359,469)	321,387			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,393,849	864,067	2,071,015	8,328,931		8,328,931	(1,480,764)	6,848,167			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(79,625)	2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,625)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (79,625)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Misericordia Home South

ID# 0005926

Report Period Beginning: 07/01/1999

Ending: 06/30/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Depreciation of Non-care & auto allocated to other	$ (5,450)	30	1
2	Fuel & repairs of Non-care & auto allocated to other	(5,416)	14	2
3	Expenses Reimbursed for Other Sources:			3
4	Dietary Wages	(10,545)	1	4
5	Dietary Supplies	(1,148)	1	5
6	Dietary Other	(1,015)	1	6
7	Food Supplies	(12,170)	2	7
8	Housekeeping Wages	(40,805)	3	8
9	Housekeeping Supplies	(11,512)	3	9
10	Housekeeping Other	(581)	3	10
11	Laundry Wages	(19,885)	4	11
12	Laundry Supplies	(1,496)	4	12
13	Heat and Other Utilities	(23,594)	5	13
14	Maintenance Wages	(47,963)	6	14
15	Maintenance Supplies	(4,835)	6	15
16	Maintenance Other	(20,880)	6	16
17	Medical Director	(788)	9	17
18	Nursing/Med Records Wages	(455,294)	10	18
19	Nursing/Med Records Supplies	(30,354)	10	19
20	Therapy Wages	(8,886)	10a	20
21	Therapy Supplies	(761)	10a	21
22	Therapy Other	(1,796)	10a	22
23	Activities Other	(9)	11	23
24	Social Services Wages	(7,079)	12	24
25	Social Services Other	(370)	12	25
26	Program Transportation	(765)	14	26
27	Administrative Wages	(20,012)	17	27
28	Professional Services	(2,214)	19	28
29	Dues, Fees, Subscriptions & Promotions	(1,812)	20	29
30	Clerical Wages	(42,908)	21	30
31	Clerical Supplies	(5,669)	21	31
32	Clerical Other	(4,103)	21	32
33	Employee Benefits & Payroll Taxes	(161,401)	22	33
34	Travel and Seminar (includes out-of-state conf)	(1,767)	24	34
35	Insurance-Prop,Liab&Malpractice	(12,426)	26	35
36	Depreciation	(75,963)	30	36
37	Ancillary Service Center Costs Allocated to Other	(359,469)	39	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
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72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(1,401,139)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Misericordia Home South # 0005926 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(12,709)	0	0	0	0	0	0	0	0	0	0	(12,709)	1
2	Food Purchase	(91,795)	0	0	0	0	0	0	0	0	0	0	(91,795)	2
3	Housekeeping	(52,897)	0	0	0	0	0	0	0	0	0	0	(52,897)	3
4	Laundry	(21,381)	0	0	0	0	0	0	0	0	0	0	(21,381)	4
5	Heat and Other Utilities	(23,594)	0	0	0	0	0	0	0	0	0	0	(23,594)	5
6	Maintenance	(73,678)	0	0	0	0	0	0	0	0	0	0	(73,678)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(276,053)	0	0	0	0	0	0	0	0	0	0	(276,053)	8
	B. Health Care and Programs													
9	Medical Director	(788)	0	0	0	0	0	0	0	0	0	0	(788)	9
10	Nursing and Medical Records	(485,648)	0	0	0	0	0	0	0	0	0	0	(485,648)	10
10a	Therapy	(11,443)	0	0	0	0	0	0	0	0	0	0	(11,443)	10a
11	Activities	(9)	0	0	0	0	0	0	0	0	0	0	(9)	11
12	Social Services	(7,449)	0	0	0	0	0	0	0	0	0	0	(7,449)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(6,181)	0	0	0	0	0	0	0	0	0	0	(6,181)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(511,518)	0	0	0	0	0	0	0	0	0	0	(511,518)	16
	C. General Administration													
17	Administrative	(20,012)	0	0	0	0	0	0	0	0	0	0	(20,012)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,214)	0	0	0	0	0	0	0	0	0	0	(2,214)	19
20	Fees, Subscriptions & Promotions	(1,812)	0	0	0	0	0	0	0	0	0	0	(1,812)	20
21	Clerical & General Office Expenses	(52,680)	0	0	0	0	0	0	0	0	0	0	(52,680)	21
22	Employee Benefits & Payroll Taxes	(161,401)	0	0	0	0	0	0	0	0	0	0	(161,401)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,767)	0	0	0	0	0	0	0	0	0	0	(1,767)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(12,426)	0	0	0	0	0	0	0	0	0	0	(12,426)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(252,311)	0	0	0	0	0	0	0	0	0	0	(252,311)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,039,882)	0	0	0	0	0	0	0	0	0	0	(1,039,882)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Misericordia Home South # 0005926 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(81,413)	0	0	0	0	0	0	0	0	0	0	(81,413)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(81,413)	0	0	0	0	0	0	0	0	0	0	(81,413)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(359,469)	0	0	0	0	0	0	0	0	0	0	(359,469)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(359,469)	0	0	0	0	0	0	0	0	0	0	(359,469)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,480,764)	0	0	0	0	0	0	0	0	0	0	(1,480,764)	45

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule "Board of Directors During FY00						
Misericordia Home, an equal opportunity employer and provider of services, is separately incorporated						
and independently funded. The Catholic Bishop of chicago, through provisions in Misericordia's						
By-Laws, and Catholic Charities, by virtue of a majority of Board membership, qualify as related organizations because						
each has the ability to influence Misericordia's operating policy.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Certain costs, primarily related to insurance and/or construction, may be		$	$	1
2	V				paid to either Catholic Charities or the Archdiocese of Chicago. Such costs are paid to these				2
3	V				organizations on a pass-through basis, as part of our participation in collective purchasing groups.				3
4	V				Our share of costs are ultimately paid to external providers not related to us.				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sr. Rosemary Connelly	Executive Director	Oversees Misericor	n/a	n/a	50+	100.00	Salary	$ 26,609	17	1
2	Margaret Murphy	Co-Director of Develc	Grants & Direct M	n/a	n/a	50+	100.00	n/a	0	n/a	2
3											3
4	*Note that Sr. Rosemary Connelly's salary is allocated between Development & Community Relations and Program MG&A (the MG&A portion is										4
5	further allocated between Misericordia North & South). Also, Margaret Murphy's salary is allocated to Development & Community Relations and is not reported										5
6	as an allowable expense on any Cost Rpt.										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 26,609		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 6/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Misericordia Home South **#** 0005926 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,756 B. General Construction Type: Exterior Brick Frame Solid Masonary Number of Stories 4 + Basement

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A for Misericordia South, only one building.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long-term Care, Day Training, School and CCI Facility			$ 9,680	1
2					2
3	TOTALS			$ 9,680	3

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	See Attached Schedule				1,954,613	77,288	5-50 yrs	77,288		1,269,903	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,954,613	$ 77,288		$ 77,288	$	$ 1,269,903	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,010,596	$ 50,482	$ 50,482	$	3-20yrs	$ 651,483	37
38	Current Year Purchases	73,709	19,203	19,203		3-20yrs	4,160	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,084,305	$ 69,685	$ 69,685	$		$ 655,643	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Residents transportation	1991 Ford E350 Van	1998	$ 2,105	$ 702	$ 702	$	3	$ 1,754	42
43										43
44										44
45										45
46	TOTALS			$ 2,105	$ 702	$ 702	$		$ 1,754	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,050,703	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 147,675	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 147,675	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,927,300	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Furn & Equip allocated to other progr	$ 307,743	$ 19,149	$ 222,587	52
53	Non-care automobiles allocated to other p	69,080	8,065	62,937	53
54	Repairs & Improv allocated to other prog	1,305,976	54,199	676,627	54
55					55
56					56
57	TOTALS	$ 1,682,799	$ 81,413	$ 962,151	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

***CNAs MUST HAVE CERTIFICATION PRIOR TO HIRING; CONSISTENT WITH PRIOR YEARS

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Misericordia Home South # 0005926 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,409,282	$	1
2	Cash-Patient Deposits	252,042		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,307,187		3
4	Supply Inventory (priced at cost)	146,474		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,114,985	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	245,000		11
12	Long-Term Investments			12
13	Land	9,680		13
14	Buildings, at Historical Cost	51,221,943		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	8,069,994		16
17	Accumulated Depreciation (book methods)	(28,660,373)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	3,928,061		22
23	Other(specify): Pledges/Contributions Rec	214,979		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 35,029,284	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 46,144,269	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 638,899	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	265,036		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,411,535		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	see attached	2,289,907		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,605,377	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Gift Annuity Liability	232,895		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 232,895	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,838,272	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 41,305,997	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 46,144,269	$	48

***(See instructions.)**

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 45,776,335	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 45,776,335	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,258,218)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	7,473,096	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Net Loss for Misericordia North**	(2,970,684)	15
16	Other (describe) **Development & Community Relations (Unallo**	(1,317,616)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,926,578	17
	B. Transfers (Itemize):		
18	**Fixed Asset Additions**	6,046,201	18
19	**Funding of Depreciation**	(2,730,703)	19
20	**Transfers to Endowment/Contingency Fund**	(9,712,414)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (6,396,916)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 41,305,997	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,490,728	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,490,728	3
	B. Ancillary Revenue		
4	Day Care	72,703	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 72,703	8
	C. Other Operating Revenue		
9	Payments for Education	423,133	9
10	Other Government Grants	84,149	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 507,282	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,070,713	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,101,323	31
32	Health Care	4,765,505	32
33	General Administration	1,552,159	33
	B. Capital Expense		
34	Ownership	229,088	34
	C. Ancillary Expense		
35	Special Cost Centers	359,469	35
36	Provider Participation Fee	321,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,328,931	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,258,218)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,258,218)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing		2,080	$ 56,476	$ 27.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses		30,903	628,771	20.35	3
4	Licensed Practical Nurses		28,451	490,854	17.25	4
5	Nurse Aides & Orderlies		184,495	2,103,894	11.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist		6,287	176,049	28.00	7
8	Rehab/Therapy Aides		9,766	125,753	12.88	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers		4,126	69,372	16.81	11
12	Dietician					12
13	Food Service Supervisor		2,110	48,474	22.97	13
14	Head Cook		2,214	31,384	14.18	14
15	Cook Helpers/Assistants		9,091	116,276	12.79	15
16	Dishwashers					16
17	Maintenance Workers		13,941	191,231	13.72	17
18	Housekeepers		13,497	136,810	10.14	18
19	Laundry		10,957	113,880	10.39	19
20	Administrator		1,562	52,839	33.83	20
21	Assistant Administrator		2,080	62,348	29.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical		14,351	246,975	17.21	24
25	Vocational Instruction		13,321	173,600	13.03	25
26	Academic Instruction		10,333	180,836	17.50	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		2,090	52,429	25.09	28
29	Resident Services Coordinator		9,160	147,397	16.09	29
30	Habilitation Aides (DD Homes)		17,983	188,201	10.47	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		388,798	$ 5,393,849 *	$ 13.87	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	355	$ 10,650	1	35
36	Medical Director	380	23,611	9	36
37	Medical Records Consultant		230	10	37
38	Nurse Consultant	27	462	10	38
39	Pharmacist Consultant		3,771	10	39
40	Physical Therapy Consultant	1,777	73,567	10a	40
41	Occupational Therapy Consultant	1,889	76,910	10a	41
42	Respiratory Therapy Consultant	82	1,630	10a	42
43	Speech Therapy Consultant	164	7,324	10a	43
44	Activity Consultant				44
45	Social Service Consultant	142	6,400	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,816	$ 204,555		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sr. Rosemary Connelly	Executive Director	n/a	$ 26,609
Betty Flynn	Administrator	n/a	26,230
Janet Bender	Assistant Administrator	n/a	62,348
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,187

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche	Audit	$ 9,177
Martin Boyer Co.	Unemployment Admin Services	593
Burke, Warren, MacKay&Seritella	Legal	399
Melnick, Baird, Williams & Fisher	Consulting	1,541
SCO Services	Computer Services - Unix	1,032
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 12,742

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,129
Unemployment Compensation Insurance	832
FICA Taxes	311,879
Employee Health Insurance	294,373
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Pension Contributions	225,536
Tuition Reimb & Other Misc	5,979
TOTAL (agree to Schedule V, line 22, col.8)	$ 884,728

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	5,703
Health Care Worker Background Check	
(Indicate # of checks performed 27)	327
Subscriptions	1,579
Membership Dues	4,172
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,782

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	15,617
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,617

**See instructions.

Facility Name & ID Number Misericordia Home South # 0005926 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Misericordia Home South # 0005926 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Health Care Association, $4,200**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **3-15 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **110,985** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **321,388**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **yes, within 50 miles of Illinois**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **not able to dete**
d. Have vehicle usage logs been maintained? **yes, for program vehicles**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes, with the exception of Non-care related vehicles**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes, with the exception of Non-care related vehicles**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Deloitte & Touche** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.